IMprove Health Clinics

Patient Acknowledgement – Receipt of Privacy Notice

I,_____

hereby affirm that I have received a copy of the Notice of Privacy Practices from Improve Health Clinics, PLLC. Under federal law 104-191, also known as HIPAA, I am entitled to receive a copy of this Notice from my healthcare provider.

I understand that my signature on this Acknowledgement only signifies that I have received a copy of the Notice, and does not legally bind or obligate me in any way.

I understand that I am entitled to receive a copy of the Notice of Privacy Practices from my healthcare provider, whether I sign this Acknowledgement or not.

_____

Patient Name

_____

Signature of Patient or Personal Representative

_____

Name of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority

FOR OFFICE USE ONLY

Received By:	
Date Received:	Time Received:
Patient Declined: ☐	
Staff Signature:	